ANNUAL REPORT
FISCAL YEAR 2004

HEALTH STRATEGIES COUNCIL OF GEORGIA

appointed by the Governor
to advise and support the health planning mission of the

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

November 2004

FROM THE CHAIRMAN

Governor Sonny Perdue
Lt. Governor Mark Taylor
Speaker of the House Glenn Richardson
Members, Georgia General Assembly
Members, Board of Community Health
Commissioner Tim Burgess

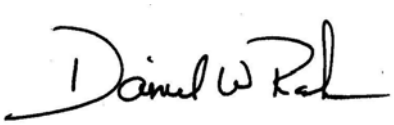
Ladies and Gentlemen:

I submit to you the 2004 Annual Report of the Health Strategies Council (Council). The Council submits policy recommendations about Georgia's health care system and the Certificate of Need program that is administered by the Georgia Department of Community Health.

In addition to its responsibilities for developing and refining the core components of Georgia's State Health Plan and Rules, the Council is also integrally involved with conducting an ongoing evaluation of Georgia's existing health care resources and providing policy guidance about financial accessibility and accountability. Most notably, during this fiscal year, the Council collaborated with the Department to undertake one of the most comprehensive updates of the State's Health Planning Administrative Rules in recent years. In the upcoming months, members will be involved in spearheading the revision of several other State Health Plans to ensure that they are sufficiently responsive to current healthcare industry trends and practices.

The Council is committed to fostering an environment that encourages the delivery of appropriate, high quality, accessible, healthcare services to all Georgians. While there are daunting challenges ahead, I submit that the Council is poised to continue to provide strong leadership and policy guidance. We thank you for your support and for the opportunity to continue to be of service to the citizens of the state.

Sincerely,



Daniel W. Rahn, MD,
Chairman

COUNCIL MEMBERS

Members of the Health Strategies Council are appointed by the Governor to represent various health care interests. Members of the Health Strategies Council and their respective affiliations and categories of representation as of June 30, 2004, are as follows:

Member and Affiliation	Category of Representation
Daniel W. Rahn, MD, *Council Chair* President, Medical College of Georgia	Member at Large
Elizabeth P. Brock, *Council Vice-Chair* President, Pallets Incorporated	Health Care Needs of Small Business
William G. Baker, Jr., MD President, Atlanta Regional Health Forum, Inc.	Health Care Needs of Low-Income Persons
Honorable Glenda M. Battle, RN, BSN Decatur County Commissioner, Bainbridge Association County Commissioners of GA	County Governments
Harve R. Bauguess President, Bauguess Management Company, Inc.	Health Care Providers – Nursing Homes
David M. Bedell, DVM Chairman, Tift County Board of Health	Health Care Needs of Older Persons
Edward J. Bonn, CHE President/CEO, Southern Regional Health System	Health Care Providers – Urban Hospitals
VACANT	Health Care Needs of Populations with Special Access Problems
Tary L. Brown CEO, Albany Area Primary Health Care, Inc.	Health Care Providers – Primary Care Centers
W. Clay Campbell Executive Vice President, Archbold Medical Center	Health Care Providers – Home Health Agencies
Nelson B. Conger, DMD Dentist	Health Care Providers – Primary Care Dentist, Dalton
Katie Foster Regional Director, Service Employees International Union	Health Care Needs of Organized Labor
Charlene M. Hanson, EdD, FNP Professor Emerita, Family Nurse Practitioner Georgia Southern University	Health Care Providers – Nurse Practitioner
VACANT	Health Care Needs of Persons with Disabilities

Reverend Ike E. Mack Pastor, Unionville Baptist Church, Warner Robins	Member at Large
Felix T. Maher, DMD Dentist, Savannah	Health Care Providers – Primary Care Dentist
Julia L. Mikell, MD Neurologist/Physician, Neurological Institute of Savannah	Health Care Providers – Specialty Physician
James C. Peak CEO, Memorial Hospital & Manor	Health Care Needs of Populations with Special Access Problems
VACANT	Health Care Needs of Large Business
Raymer Sale, Jr. , CLU President, E2E Resources, Inc. Lawrenceville	Private Insurance Industry
Toby D. Sidman Georgia Breast Cancer Coalition & Fund	Health Care Needs of Women
Cathy P. Slade Director, Georgia Medical Center Authority	Health Care Needs of Populations with Special Access Problems
Oscar S. Spivey, MD Professor and Chairman Emeritus of Pediatrics Mercer University School of Medicine	Health Care Needs of Children
Tracy Michele Strickland Associate, Life Science Practice Group, Spencer Stuart	Member at Large
Kurt Stuenkel, FACHE President & CEO, Floyd Medical Center	Health Care Providers – Rural Hospitals
Kay L. Wetherbee, RN Principal, Encounter Technology	Health Care Providers – Registered Nurse
David M. Williams, MD President/CEO, Southside Medical Center	Health Care Providers – Primary Care Physician

OVERVIEW

The Health Strategies Council is responsible for developing Georgia's State Health Plan and addressing policy issues concerning access to health care services. The members of the Council are appointed by the Governor and represent a wide range of health care and consumer interests. The Council focuses on providing policy direction and health planning guidance for the Division of Health Planning, the Office of General Counsel, and, where appropriate, the Department of Community Health as a whole.

The functions of the Council are set forth in O.C.G.A. 31-6-21 and provide for the Council to:

- Adopt the state health plan and submit it to the [Board of Community Health] for approval which shall include all of the components of the Council's functions and be regularly updated;
- Review, comment on, and make recommendations to the Department on the proposed rules for the administration of this chapter, except emergency rules, prior to their adoption by the Department;
- Conduct an ongoing evaluation of Georgia's existing health care resources for accessibility, including but not limited to financial, geographic, cultural, and administrative accessibility, quality, comprehensiveness, and cost;
- Study long-term comprehensive approaches to providing health insurance to the entire population; and
- Perform such other functions as may be specified for the council by the Department or the board.

The role and impact of the Health Strategies Council has continued to expand and has strengthened over time and during Fiscal Year 2004. To fulfill its broad mission, the Council holds quarterly public meetings and regularly convenes committees consisting of providers, advocates and technical experts to advise the Department and the Division on the need for changes and improvements to the state health plan.

The Council has continued to play a key role in the updating of the Certificate of Need plans and rules to reflect the state's healthcare priorities while keeping the needs of Georgia's citizens at the forefront of the planning process. The Council is committed to ensuring planning policies that incorporate access, stewardship, quality of care, integration of healthcare services and the improvement of the health status of Georgia's citizens.

GEORGIA'S STATE HEALTH PLAN

A major duty of the Health Strategies Council is the development and ongoing refinement of Georgia's State Health Plan. The current State Health Plan consists of thirteen (13) comprehensive component plans addressing a wide range of health care services and facilities. In most cases, these component plans serve as the basis for administrative rules and regulations governing the certificate-of-need process and integration with other department programs. The Council also uses the health planning process to promote the achievement of community wellness and access to care, as well as the broader health missions of the Department of Community Health, the Governor and the State of Georgia.

The process of developing new or revised components for the State Health Plan often involves the appointment of advisory committees whose members bring a range of technical expertise to the development process. Members of these committees are carefully selected to include providers, consumers, payers, regulators, and other interested parties. Each proposed change to the State Health Plan and any resulting rule changes must undergo a public review and comment process. Also, the Department and the Board of Community Health must approve any changes to the components of the State Health Plan.

COMPONENTS OF THE STATE HEALTH PLAN

COMPONENT PLAN	DATE OF LATEST ADOPTION
Ambulatory Surgical Services	June 1998**
Continuing Care Retirement Community	January 1998
Home Health Services	February 2001*
Inpatient Physical Rehabilitation Services	October 1994
Nursing Facilities	August 2000
Perinatal Health Services	February 1999
Personal Care Homes	August 2001
Positron Emission Tomography (PET) Services	February 2002
Psychiatric and Substance Abuse Inpatient Services	July 1990
Radiation Therapy Services	May 2001

Short-Stay General Hospital Beds	April 2003
Specialized Cardiovascular Services • Adult Cardiac Catheterization • Open-heart Surgical Services • Pediatric Cardiovascular Services	May 2001
Traumatic Brain Injury	May 1990

Note:
**revisions in process.
*partial updates were made in FY 2003

FISCAL YEAR 2004 ACCOMPLISHMENTS

During FY 2004, the three Standing Committees of the Health Strategies Council namely, Acute Care, Long Term Care, and the Special and Other Services Committees met to review the thirteen components of the state health plan. The purpose of each committee is to annually review the components of the state health plan and to make recommendations to the Health Strategies Council about the need for revisions and updates.

The Standing Committees met during January 2004. Committee members utilized a wide range of mechanisms to inform their decision-making process, including presentations from industry representatives, oral and written public comments and information and data from the Department of Community Health.

Each Council member was asked to serve on at least one Standing Committee. The Council Chair served as an ex-officio member of each committee. Committee members appear below:

Acute Care Committee	**Long Term Care Committee**	**Special & Other Services Committee**
+ *Kurt M. Stuenkel, FACHE*	+*W. Clay Campbell*	+*David M. Williams, MD*
Glenda Battle, RN	Elizabeth Brock	William G. Baker, Jr., MD
Edward J. Bonn	Harve R. Bauguess	David Bedell, DVM
Katie Foster	Tary Brown	Nelson B. Conger, DMD
James Peak	Dr. Charlene Hanson	Felix Maher, DMD
Oscar Spivey, MD	Reverend Ike E. Mack	Toby D. Sidman
Tracey Strickland	Julia L. Mikell, MD	Cathy Slade
VACANT	Raymer Sale, Jr	Kay Wetherbee
	VACANT	
	VACANT	

Note: + Committee Chairperson

The three Standing Committees addressed each of the following components of the State Health Plan:

Acute Care Services	Long Term Care	Special and Other Services
General Short Stay Hospital Services	Nursing Facilities	Positron Emission Tomography
Open-Heart Surgical Services	Personal Care Homes	Radiation Therapy Services
Perinatal Health Services	Home Health Services	Ambulatory Surgical Services
Psychiatric & Substance Abuse Inpatient Services	Inpatient Physical Rehabilitation Services	
Cardiac Catheterization Services	Traumatic Brain Injury Programs	
	Continuing Care Retirement Communities	

Below is a summary of the recommendations of the Standing Committees and a synopsis of other ongoing health planning activities that were undertaken in several areas during FY2004.

ACUTE CARE SERVICES STANDING COMMITTEE

The Acute Care Standing Committee, chaired by Kurt Stuenkel, FACHE, recommended that there be no changes to the State Health Plan and Rules which govern Short Stay General Hospital Beds and Perinatal Health Services. They recommended the establishment of a technical advisory committee (TAC) that would review the State Health Plan and Rules for Psychiatric & Substance Abuse Inpatient Services, given that this plan was last updated in 1990 and also recommended that the Specialized Cardiovascular Services TAC be reconvened to reconsider allowing primary and elective angioplasty without on-site open-heart surgical services in selected Georgia hospitals. This committee endorsed the recommendations of the Special & Other Services Standing Committee to remove the annual review of the Plan and Rules for Open Heart Surgical Service from the purview of their committee to the auspices of the Acute Care Standing Committee.

LONG TERM CARE SERVICES STANDING COMMITTEE

The Long Term Care Standing Committee, chaired by W. Clay Campbell, invited industry representatives to speak at its annual meeting. Following significant discussion and input the committee recommended that there be no changes to the State Health Plans and Rules for Personal Care Homes, Home Health Services, Nursing Facilities, or Continuing Care Retirement Communities. The Standing Committee endorsed the Department's recommendations regarding the need to establish a technical advisory committee to develop a State Health Plan and Rules for Long Term Acute Care beds and to update the outdated Plans and Rules that govern Inpatient Physical Rehabilitation Services and Traumatic Brain Injury Programs which were developed in 1994 and 1990 respectively.

SPECIAL & OTHER SERVICES STANDING COMMITTEE

The Special and Other Services Committee, chaired by David M. Williams, MD, made no recommendations for changes to the State Health Plans and Rules that govern Positron Emission Tomography and Radiation Therapy Services. They recommended that review of the Cardiac Catheterization Services Plan and Rules be removed from the jurisdiction of their committee and be placed under the auspices of the Acute Care Standing Committee where they could more appropriately be reviewed in concert with the Open-Heart Surgical Services Plan and Rules. The Committee endorsed the Department's recommendation to establish a technical advisory committee to determine the need for a State Health Plan and Rules for Gamma Knife technology.

ONGOING HEALTH PLANNING ACTIVITIES

❖ AMBULATORY SURGICAL SERVICES

William G. "Buck" Baker, Jr. MD, President, Atlanta Regional Health Forum, Inc., and member of the Council, chairs this 18-member group.

During FY2003 the Board of the Department of Community Health charged the Division of Health Planning and the Council with reviewing and updating the Ambulatory Surgery Services Plan and Rules following concerns that were raised about elements of the need methodology, health planning areas, and adverse impact on other providers. At its February 2003 meeting, the Council voted to convene an Ambulatory Surgical Services Technical Advisory Committee (TAC). Members of the 2003 Ambulatory Surgical Services TAC represent various geographic regions of the state and are members of a wide variety of constituent groups, including state agencies, consumers, professional associations, advocates, provider groups, and payors. The TAC was asked to develop a new component plan and related rules to govern the establishment, replacement or expansion of freestanding ambulatory surgery services governed by the Certificate of Need process. In addition to hosting a public forum, the TAC met five times between May 2003 and November 2003 and produced draft plan and rules. Because of concerns that were raised by the Department and other constituents regarding these draft documents, the Office of Attorney General was consulted to provide some legal guidance. The TAC did not meet during FY2004 but is expected to resume committee deliberations following policy direction from the Office of Attorney General.

❖ SPECIALIZED CARDIOVASCULAR SERVICES

Elizabeth Brock, President, Pallets Incorporated, and member of the Council, chaired this 21-member group.

The Specialized Cardiovascular Services Technical Advisory Committee was reconvened during FY2003 to consider any potential changes to the current plans and rules based on the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) recently published findings of research undertaken between 1996 and 1999 in Massachusetts and Maryland. The research found that

treating patients with percutaneous coronary interventions (angioplasty) in emergency situations was beneficial in particular instances and in certain settings without on-site open-heart surgical backup. The Council limited the committee's charge to issues relating to the regulatory guidelines for PCI and issues of cost, quality, capacity, and access. The TAC met twice and grappled with the fact that neither the American College of Cardiology (ACC) nor any other state, including Maryland where the study occurred, had yet made changes in their regulatory guidelines based on the C-PORT study. Recognizing that some research is continuing (in New York and New Jersey) and that the ACC would be reevaluating their clinical guidelines, the TAC asked the staff to continue to monitor emerging research and issues in this area. The TAC agreed to reconvene again should the ACC make any changes to their guidelines.

While the ACC has not made any changes to its guidelines, the Council became aware of emerging research spearheaded by Atlantic Cardiovascular Patient Outcomes Research Team ("C-PORT II") which would allow selected hospitals to participate in a study protocol to provide primary and elective angioplasty without on-site open-heart surgical services. During FY2004, the Council, together with the Department, invited and hosted the principal investigator, Thomas Aversano, MD to the State of Georgia to obtain additional information about this study.

In his address to the Council, Dr. Aversano indicated that the motivation behind this project is the need for research to examine the safety and efficacy of this treatment modality and to further examine factors relating to continuity of care and regionalization of these specialized services. The Council recommended that the Department develop draft rules to allow participation in the registry phase of the "CPORT I" study (primary angioplasty) and the randomized control trial study "CPORT II" (non-primary angioplasty). The Department is expected to draft other selection criteria which hospitals would be required to meet in order to participate in this research project, pending review of the study protocol and other guidelines issued by CPORT.

❖ HEALTH CARE WORKFORCE PLANNING

The Health Strategies Council was instrumental in promoting the formation of the Health Care Workforce Policy Advisory Committee which was charged with overseeing non-physician workforce planning and providing short and long term solutions to the growing shortage of healthcare professionals in nursing, allied health and behavioral health disciplines. While funding for this program ceased during FY 2004, Division of Health Planning staff continues to monitor and track the productivity of initiatives that were instituted by this committee. Among the ongoing activities are the following:

- Coordination of funding requirements of Robert Woodruff Foundation to the Georgia Student Finance Commission (GSFC);
- Collaboration with Department of Labor to ensure GSFC funds are being appropriately allocated;
- Coordination and submission of reports to the Robert Woodruff Foundation to ensure financial support to statewide nursing programs;
- Monitoring and management of healthcare workforce contracts and deliverables;
- Providing support and technical assistance to statewide pilot project initiatives

❖ PROPOSED HEALTH PLANNING RULES

During FY2004, the Department and the Council streamlined and standardize the CON review process by updating the Health Planning Administrative Rules. Several opportunities for public comment were afforded to the community during the development process, including one in-person and two telephone conference call meetings of the Health Strategies Council. Additionally, the Department held a working session with a wide range of constituents and hosted a public hearing. Some technical modifications were made to the Rules, including renumbering and clarification, however much of the proposed changes provided guidance and clarified how the Department would interpret the Health Planning Administrative Rules.

❖ INDIGENT AND CHARITY CARE

A key component of each Certificate of Need application is the requirement to provide the Department with requested information and statistical data related to the operation of healthcare facilities and the provision of services. Collection of uniform data from providers allows more precise assessment of service patterns and projected service needs that are critical for health planning purposes. During the review of the Health Planning Administrative Rules, concerns were raised about how providers calculate and report indigent and charity care data. Furthermore, the Department is aware of confusion and inconsistency in the application of the Department's definitions of indigent and charity care and of instances of the mistaken use of Bad Debt as a component of a provider's indigent or charity care write-off. All of these inconsistencies impact the Department's ability to adequately assess whether the healthcare needs of Georgia citizens are being met.

The Health Strategies Council recommended the establishment of an Indigent and Charity Care Ad Hoc Committee to review the Department's current definitions of indigent and charity care and to provide the Department with clear definitions that would provide uniformity and equity for providers when collecting, calculating, and reporting indigent and charity care in the state.

The Council and the Department are committed to fostering an environment that encourages the delivery of appropriate healthcare services to all Georgia citizens, including the provision of indigent and charity care services and to ensuring that providers fulfill commitments made during the Certificate of Need application process, including adhering to uniform data collection and reporting requirements.

DEPARTMENT INITIATIVES

The Council actively supported a number of key initiatives of the Department, offering technical assistance, support, and policy guidance in the following areas:

- Document Management System: At present, the Department has a paper-based system for filing and storing documents related to the State Health Plan, CON Applications and CON-related files. The Department is undertaking a rigorous process of selecting, developing and implementing a document management system to convert CON applications, decisions, and related files to a standard electronic format. This format will provide the public, customers, and staff more efficient access to CON files and would enable the Department to accomplish its mission of fostering an efficient, effective, high-quality health care system that is accessible to all Georgians.

- ❖ Data Collection: The Department has been collaborating with the Georgia Hospital Association, the Department of Human Resources, and other state agencies to fine-tune the state's data collection processes. This is an ongoing initiative which is aimed at decreasing the burden of data reporting to providers around the state.

EDUCATIONAL OPPORTUNITY

During FY04 Council members were provided with an opportunity to learn about some of the work of their colleagues on the Council. William G. "Buck" Baker Jr., MD, President, Atlanta Regional Health Forum, Inc., (ARHF) presented "C*reating Healthy Neighborhoods: Using Community Voices and Existing Resources in the Five Core Counties of Metropolitan Atlanta*". In his presentation to the Council, Dr. Baker outlined some of the strategies that the ARHF are using to access and prioritize community health needs to assure an adequate supply of healthcare providers. This report highlighted some of the perceptions of health, as measured by some residents of Metropolitan Atlanta. It also identified current assets and presented ideal solutions to some issues facing Metropolitan Atlanta residents. The ARHF hope to inspire the creation of healthy neighborhoods through collaborative regional planning efforts.

CERTIFICATE OF NEED

The development of the Certificate of Need plans and rules along with the collection and analysis of information about Georgia's health care system are the cornerstone of the Division of Health Planning's responsibilities. The Health Strategies Council provides policy guidance to the Division and the Department while the Office of General Counsel, among other things, manages the CON review and implementation process, following adoption of the plans and rules by the Health Strategies Council and the Board of Community Health.

A Certificate of Need (CON) is a document issued by the Department of Community Health that indicates that a proposed health care project is necessary to meet community needs. Georgia's Health Planning Statute, Title 31, Chapter 6, requires the issuance of a CON before proceeding with certain kinds of health care projects. Georgia's Health Planning Statute covers almost all health care facilities, including:

- All public and private hospitals, including general, acute-care, and specialized hospitals;
- Nursing homes;
- Ambulatory surgical services or obstetrical facilities;

- Personal care homes (with 25 or more beds);
- Home health agencies
- Inpatient rehabilitation facilities treating traumatic brain injury;
- Diagnostic, treatment and rehabilitation centers (whether for-profit or not-for-profit). These facilities must obtain a CON before:
    - Offering radiation therapy, biliary lithotripsy, cardiac catheterization, or surgical procedures outside a hospital setting; or
    - Acquiring any diagnostic or therapeutic equipment exceeding the equipment threshold.

A CON is required before a health care facility can:

- Proceed with a construction or renovation project or any other capital expenditure that exceeds the construction threshold;
- Purchase or lease major medical equipment that exceeds the threshold amount for equipment acquisition;
- Offer a health care service which was not provided on a regular basis during the previous 12-month period; or
- Add new beds.

Below is a summary of the Certificate of Need applications that were submitted to the Department for review from FY1996 to FY2004. While there were fluctuations in the number of applications submitted each fiscal year between 1996 through 2001, FY2002 through FY2004 showed the largest increases in the number of applications submitted. During FY2003, 130 applications were submitted, 79% of which were approved, 12% were denied, and 8% were withdrawn prior. Twenty-four percent (24%) of all decisions were administratively appealed however the Health Planning Review Board reversed only 2%. During FY2004, 142 applications were submitted, 77% were approved, 18% were denied and 6% were withdrawn prior to the regulatory review decision. Twenty-four percent (24%) were administratively appealed but only 1% was reversed. Interestingly, while the number of applications continued to increase during FY2002-2004, the number of reversals of Department decisions by the Health Planning Review Board remained relatively low. This is a testament of the stringency of the existing state health plans and rules and the ability of the staff to effectively administer the rules. The Council and the Department are committed to continuing to provide sound health planning policies and processes that would best serve the interests of the citizens of the State of Georgia.

DEPARTMENT OF COMMUNITY HEALTH

SUMMARY OF CERTIFICATE OF NEED APPLICATIONS
FY1996 - 2004

Fiscal Year Submitted	Applications Submitted	APPROVED	%	DENIED	%	WITHDRAWN PRIOR TO REVIEW	%	APPEALED	%	REVERSALS	%
1996	76	59	(78%)	8	(11%)	9	(12%)	22	(33%)	3	(4%)
1997	71	50	(70%)	13	(18%)	8	(11%)	28	(44%)	3	(5%)
1998	93	45	(48%)	36	(39%)	12	(13%)	37	(46%)	3	(4%)
1999	95	69	(73%)	14	(15%)	12	(13%)	11	(13%)	4	(5%)
2000	85	77	(91%)	2	(2%)	6	(7%)	1	(1%)	1	(1%)
2001	91	72	(79%)	8	(9%)	11	(12%)	24	(30%)	13	(16%)
2002	117	105	(90%)	4	(3%)	8	(7%)	12	(11%)	2	(2%)
2003	130	103	(79%)	16	(12%)	11	(8%)	29	(24%)	2	(2%)
2004	142	109	(77%)	25	(18%)	8	(6%)	32	(24%)	1	(1%)
TOTAL	**900**	**689**	**77%**	**126**	**14%**	**85**	**9%**	**196**	**24%**	**32**	**4%**

NOTES

Withdrawn - Withdrawn prior to a DHP decision
Appealed - Information is incomplete for appeals submitted between 6/2000 and 10/2001; information for appeals submitted prior to 7/84 may not be reliable
Percent Appealed - The percentage of DHP decisions that is appealed; not valid if you have selected all years
Decisions Reversed - Refers to DHP decisions that are reversed upon Administrative Appeal or Judicial Review; does not take into account instances in which projects were remanded to DHP and the agency changed its decision; not available prior to 1989.

Published for the Health Strategies Council
by the Division of Health Planning
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